Who Are People with Psychiatric Disabilities?

People with psychiatric disabilities are as complex and diverse as the population in general. Hence the way to start a discussion on psychiatric rehabilitation is by understanding who the persons with psychiatric disabilities are. **People with psychiatric disabilities are, because of mental illness, unable to attain age- and culture-appropriate goals for extended periods of time.**

This definition contains three parts. First, psychiatric disabilities are based on diagnosable mental illness. This chapter reviews important components of psychiatric diagnosis, focusing on those diagnoses that are most relevant to psychiatric rehabilitation. Second, a person with a psychiatric disability is not able to pursue significant life goals because of the mental illness. Goals make sense in context, in terms of the community and culture in which the person lives. “ Appropriateness” of goals may vary by age (e.g., schooling for young people, employment for adults) and culture (e.g., Asian cultures may view family involvement differently than European cultures do). Examples of important life goals relate to income, work, and vocation; relationships, intimacy, commitment, and family; physical, dental, and mental health; and recreation and spirituality. Rehabilitation providers need to be vigilant about sensitivity to context. What might seem like an odd goal in one context might make sense in another. Ultimately, people decide for themselves which goals they wish to pursue.

Third, both the mental illness and its interference with the attainment of goals persist for significant periods of time, in most cases for years. Some people experience illnesses that might be considered serious, but quickly adapt and move on. Because of illness or context, disabilities have a major impact on people for significant portions of their lives.

Four conceptual domains are important for understanding the nature of psychiatric disabilities.

1. **Diagnoses** represent the collections of symptoms and dysfunctions that cohere to form meaningful psychiatric syndromes. Typically, diagnoses that are the foci of psychiatric rehabilitation include schizophrenia, the mood disorders (such as major depression and bipolar disorder), some anxiety disorders and related disorders (such as posttraumatic stress disorder [PTSD] and obsessive–compulsive disorder [OCD], which were formerly classified with the anxiety disorders but now have their own categories in DSM-5), and some personality disorders.
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2. Course. Psychiatric syndromes are not static phenomena. They vary among individuals in terms of onset and trajectory. A syndrome also varies within an individual over time in terms of the severity of symptoms and dysfunctions.

3. Co-occurring disorders. Psychiatric disorders rarely occur in isolation, without associated disorders. Instead, many people with psychiatric disabilities experience multiple diagnoses, which interact to impede their life goals significantly. Substance use disorders, in particular, frequently co-occur with serious mental illness to worsen disease course.

4. Disabilities, as indicated above, refer to the inability of people to meet life goals that are appropriate for their age and culture. These tend to be macro-level goals that include obtaining a satisfactory job, living independently, developing intimate and mature relationships, managing physical and mental health needs, and enjoying life through recreational and spiritual pursuits. Note that it is disability per se that defines a person as being in need of psychiatric rehabilitation. People can have psychiatric diagnoses—some that are severe, and others that are long-lasting—that do not interfere with their life goals. What distinguishes rehabilitation from other forms of psychiatric care is the focus on helping people achieve life goals that are blocked by symptoms and dysfunctions. Each of these four conceptual domains is reviewed more fully in the remainder of this chapter.

There can be significant problems in discussions that focus on diagnoses, symptoms, dysfunctions, and disabilities: Such discussions can reduce people to the sum of their problems. Although a pathology-based perspective is useful for understanding mental

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PERSONAL EXAMPLES

Four Life Stories

Veronica Howard had lived on the streets since she was 18. She had neither a steady job nor a regular income. She preferred the cold pedestrian tunnels under the freeway to the homeless shelters, because she was deathly afraid of other people. Veronica wore dirty clothes and had poor hygiene. She also had difficulty managing her diabetes because of her poor diet.

Joel Jenkins was 22 years old when he was brought into the emergency room of the state psychiatric hospital by the police. He was extremely agitated, shouting at imaginary demons and thrashing at the officers. This was his third admission to the hospital in the past 6 months. His parents were frightened of Joel’s recurring “craziness” and feared they would soon have to “put him away” in an institution. The police officers in the small town where Joel lived were afraid that the next time they were called to his home, the arrest could escalate into someone’s getting hurt. They were also concerned that Joel might be using marijuana, because some was found in his pants pocket during his last arrest.

George Miller rarely comes out of his apartment. It’s not that he is afraid of people; rather, he just seems to have no interest in them. He does not particularly care about working with others, making small talk when he meets neighbors at the park, or joining friends and family for a holiday meal. For that matter, he has no interest in finding a girlfriend or in settling down.

Harriet Osborne wants to get a job, live on her own, find a husband, and settle down to have a family. But she has been hospitalized six times for mental illness and is afraid she will not be able to handle these goals. So, instead, she goes to a recreational program each day, where she is bored with doing the same routine of crafts and board games.
disorder and its impact on a person, pathology ignores the individual’s strengths, and this omission has unintended consequences (Rapp, 1998). Focusing on limitations adds to the person’s feeling of incompetence and stigma. Moreover, ignoring strengths misses resources that the person and rehabilitation team may use to advance the person’s goals. Given the importance of a strengths-based perspective, the chapter ends with a fuller discussion of this area.

**PSYCHIATRIC DIAGNOSIS**

Many countries use the *International Classification of Diseases and Related Health Problems* (now in its 10th revision and known as ICD-10; World Health Organization [WHO], 1992, 1993, 1994) as a resource for psychiatric diagnosis. Although ICD-10 is a reference for all disease, the section on mental disorders is specific to psychiatric diagnosis. Psychiatric rehabilitation practitioners in the United States and some other countries rely on the *Diagnostic and Statistical Manual of Mental Disorders*; DSM is currently in its fifth edition (DSM-5; American Psychiatric Association, 2013), which replaced DSM-IV, published almost 20 years before (American Psychiatric Association, 1994). Although there are some minor differences across manuals, researchers have attempted to make sure that DSM and ICD correspond as the references continue to develop. DSM-IV, as DSM-III (American Psychiatric Association, 1980) did before it, defined diagnosis in terms of five axes. Axis I listed the psychiatric diagnoses apart from personality disorders and mental retardation, which were listed in Axis II. Axis III listed general medical conditions that might be related to the psychiatric disorders. Axis IV specified psychosocial and environmental problems. Axis V represented a global assessment of functioning. DSM-5 has instituted a significant shift by replacing the five axes with a single diagnosis or set of diagnoses. Like its predecessors, it specifies criteria for making diagnoses (although the criteria for many diagnoses have also undergone revision). For example, two or more of the following need to be exhibited during a 1-month period for a person to be diagnosed with schizophrenia: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, or negative symptoms. Other criteria (regarding the duration of the symptoms, the resulting level of functioning, etc.) must also be met.

Although DSM includes diagnoses relevant to all age groups, disorders of interest to psychiatric rehabilitation are generally dominated by adult syndromes. In part, this is the case because the onset of many major mental illnesses (e.g., schizophrenia and the mood disorders) occurs in late adolescence or young adulthood. The focus on adult disorders also occurs because disabilities (defined as blocked life goals) are most meaningful in adulthood, when various goals like work, relationships, and independent living are ordinarily achieved. Hence psychiatric disorders related to children (e.g., attention deficit/hyperactivity disorder or developmental disabilities) and those with onset in later life (e.g., major or mild neurocognitive disorder due to Alzheimer’s disease) are typically not the focus of psychiatric rehabilitation.

WHO (2001) developed the *International Classification of Functioning, Disability, and Health* (ICF) to parallel the goals of ICD-10 and DSM-5. ICF integrates medical and social aspects of a disorder into a single classification. It echoes the earlier statement that problems can only be understood in terms of context. Hence ICF describes disability and functioning in terms of *health conditions* (diseases, disorders, and injuries) and *contextual factors*. It further divides context into *environmental factors* (e.g., social attitudes, architectural characteristics, legal structures, climate, and terrain) and *internal personal*
factors (e.g., gender, age, coping styles, social background, education, and profession). These descriptors are then used to classify people into more than 50 core sets. For the most part, ICF has not been used in rehabilitation practice in the United States. However, it is an important set of guidelines that reminds the provider of the importance of context in describing disabilities.

CHARACTERISTIC DIAGNOSES

Diagnoses in DSM represent syndromes, or collections of symptoms that have meaning for an understanding of etiology (causes of a disorder) and treatment. In addition, specific disorders tend to be associated with dysfunctions (e.g., poor social skills) that, when combined with symptoms, prevent persons from achieving life goals. Finally, diagnosis is fundamental for answering epidemiological questions—namely, questions about the distribution of mental disorders in the population and associated risk factors. DSM refers to the various diagnoses as disorders. A psychiatric disorder is a clinically significant behavioral or psychological syndrome that is associated with distress or dysfunction or with increased risk of death, disability, pain, or loss of freedom (American Psychiatric Association, 2000a, 2013). Describing a condition as clinically significant generally means that the condition is severe enough that treatment would be recommended or sought out.

Symptoms and Dysfunctions

Although DSM is largely silent about the difference between symptoms and dysfunctions, symptoms tend to be the additional negative experiences that occur because of an illness, while dysfunctions represent the absence of normal functioning. Both of these are evident in four fundamental spheres of human psychology: affect; perception and cognition; motivation and behavior; and interpersonal functioning. Note that reviewing symptoms and dysfunctions in terms of these four spheres implies that symptoms are not necessarily linked to specific disorders. For example, hallucinations and depression occur in several different disorders. Although psychopathology researchers formerly looked for the single symptom that unequivocally signaled a specific disorder, these efforts have been largely unsuccessful. It is the collection of symptoms, with corresponding course and disabilities, that defines a diagnosis.

Affect

Four types of mood-related symptoms may constitute a psychiatric disorder: depression, euphoria, anxiety, and anger. These are distinguished from the normal range of positive and negative emotions by their severity or the length of time for which they have been experienced. For example, feeling anxious before a test is common and perhaps adaptive, because it motivates a person to be prepared. Feeling anxious about a test all semester is likely to be overwhelming and to interfere with activities outside of school.

Depression is a feeling of sadness, or being blue; commonly associated with depression is anhedonia (a lack of enjoyment in life activities, especially those that were previously enjoyable). On the opposite end of the continuum from depression is euphoria, an overwhelming feeling of intense pleasure and well-being that can lead to uncontrollable excitement and regrettable behavior. Anxiety has both cognitive and physical
components. Worrying or ruminating over a stressor is the cognitive component. The physiological or autonomic components of anxiety include rapid heartbeat, shortness of breath, profuse sweating, and/or muscle ache (especially in the head and neck). Finally, some people have significant anger problems, marked by sudden and uncontrollable rage that can escalate into violence.

Alternatively, affective symptoms may appear in terms of disordered modulation. Inappropriate affect refers to emotions that are not consistent with the situation (e.g., uncontrollable laughter when learning of the death of a friend, or sobbing while watching a comedy). Affective lability means rapid change from one emotion to the next. An emotionally labile person may swing from crying to anger to laughter during the course of a 3-minute conversation. Dysfunctions in affect are also evident in some psychiatric disorders. Most common among these is flat affect, or responding to normally emotional situations with almost no signs of emotion. For example, a person with flat affect may seem to show no grief at the death of a loved one and no joy at winning the lottery.

Perception and Cognition

Distortions in perception that lead to significant disability are observed in several psychotic disorders, or mood disorders with psychotic features. These distortions include four types of hallucinations: auditory (which are the most commonly experienced in schizophrenia and are often reported as voices), olfactory (which are more commonly associated with major depressive disorder and include putrid odors of decay), tactile, and visual. Psychosis is also associated with two cognitive symptoms: delusions, which are erroneous beliefs that might include grandiose, religious, persecutory, referential, or somatic content; and disorganized speech, where syntax and semantics that govern the meaning of discourse are absent, and content may approach nonsense. Depression is associated with world views and self-views of helplessness, hopelessness, and worthlessness. Anxiety is often associated with another kind of cognitive symptom: obsessive thoughts. Obsessions are persistent ideas, impulses, or images that are experienced as intrusive and that cause marked distress.

Two dysfunctions may be observed in the perceptual and cognitive sphere. First, people with some psychiatric disorders may show deficits in attention and other information-processing abilities. This may include problems with maintenance, span, and selectivity of attention. People with manic episodes may have diminished attention because of distractibility (i.e., attention easily drawn to irrelevant stimuli). Additional deficits have been found in such cognitive functions as short- and long-term memory, and the executive functions that help people organize individual processes into an efficient decision-making system (Lesh, Niendam, Minzenberg, & Carter, 2011; Robinson et al., 2006). In addition, some people show problems with impoverished thought: They are unable to generate many ideas spontaneously in response to an issue. Alogia is common for a person with impoverished thought: speech marked by minimal words and little initiation of conversation.

Motivation and Behavior

Symptoms and deficits related to motivation manifest themselves in different ways. First, people with mood disorders typically show motivational problems. For instance, those with overwhelming euphoria may experience an expansive approach to life; namely, they
feel that there are no limits to what they might accomplish. Conversely, those who are depressed may be *lethargic* and have difficulty completing everyday activities, such as basic hygiene and work duties. Some people may experience *inhibitions* because of their disorders. Those with significant anxiety disorders or related disorders are unable to accomplish daily activities because they avoid situations that make them anxious, or because they are overwhelmed with worry. *Disinhibition* is common in some other important disorders; these include some sexual and eating disorders. Disinhibition-related syndromes of particular concern to psychiatric rehabilitation are the various substance use disorders (e.g., inability to inhibit inappropriate impulses because of intoxication).

I also list symptoms related to behavior under motivation. These include the disorganized or catatonic behavior found in some psychotic disorders. *Catatonic* behavior includes opposite ends of the same spectrum—motoric immobility or excessive motoric activity. Grossly *disorganized* behavior, seen in some forms of schizophrenia, includes childlike silliness or unpredictable agitation. Behavior-related symptoms also include *manic* or *hypomanic* activities, which are found in the corresponding phases of bipolar disorders. These symptoms include pressure to keep talking, marked increase in goal-directed activity, and/or excessive involvement in pleasurable activity. Depression is also associated with behavior change: *psychomotor agitation*, in which the individual paces or cannot sit still; and the opposite, *psychomotor retardation*, in which the individual moves, thinks, and talks more slowly than usual. Perhaps the major dysfunction most related to motivation is *avolition*, which is characterized by an inability to initiate and persist in goal-directed activities. People manifesting this symptom rarely show interest in work or social activities.

**Interpersonal Functioning**

Social relationships are at the heart of psychological functioning and are fundamental to most life goals. Many psychiatric disorders have a significant impact on the ability to form or maintain these relationships. Interestingly, most of the symptoms and dysfunctions in interpersonal relationships represent interactions with the three previous spheres of functioning: affect, cognition, and motivation. In terms of affect, social anxiety can cripple a person’s abilities to engage in and enjoy interpersonal transactions. Depression can rob a person’s interest in others or make others unrewarding to be around. Euphoria can change interactions into overly energetic and unpredictable affairs. Anger and rage can fill others with dread or leave them feeling victimized. Hallucinations and delusions can make it difficult for people to form close and intimate bonds because their perspectives on the world, including a shared reality, fail to correspond with the perspectives of others.

Symptoms and dysfunctions in cognition also undermine a person’s interpersonal experiences (Corrigan & Penn, 2001). They may prevent the person from correctly perceiving the social cues of a situation, or from understanding the roles and goals that govern it. Problems with motivation may also have an impact on interpersonal activities. The loss of motivation common to some disorders leaves some individuals with a total lack of interest in social interactions. People with this deficit, called *schizoid* symptomatology, do not necessarily fear others or have their interpersonal drive suppressed by depression. Rather, they seem to have no natural desire for any aspect of the multilevel benefits of human interaction.

Significant work has focused on understanding the deficits and dysfunctions related
to social functioning and social skills (De Silva, Cooper, Li, Lund, & Patel, 2013; Ikebuchi, 2007). Social functioning deficits can prevent people from attaining age-appropriate social roles. For young to middle-aged North American adults, these roles may include employee, head of household, spouse/partner, parent, neighbor, and member of a religious community. People with some psychiatric disorders lack the social skills that would enable them to achieve social roles. These include interpersonal skills, such as basic conversation, assertiveness, conflict management, and dating skills. They also include personal and instrumental skills, such as hygiene, money management, and basic work skills.

**Suicide and Dangerousness**

Many people with psychosis or other serious mental illnesses struggle with suicidal thoughts and impulses; hence this is an important concern for rehabilitation providers, who should be aware of and ready to intervene in all such cases. Recent epidemiological research has shown that each year, more than 35,000 reported deaths are attributed to suicide (Han, McKeon, & Gfroerer, 2014). Prevalence of suicidal ideation is particularly high in adults with major depression and substance use disorders. Suicidal ideation or attempt is one of the criteria for the diagnosis of major depression, though not all people who qualify for this diagnosis are suicidal. The interested reader should review Chapter 4, where some considerations for suicide assessment are reviewed. Two points are mentioned here:

1. Past suicidal ideation or attempts serve as important information for determining whether a person is suicidal and for developing an appropriate intervention plan.
2. Risk of suicide does not necessarily mean that a person should be hospitalized or rule the person out from pursuing other rehabilitation goals.

Answers to difficult issues like these need to involve the person with disability, his or her family, and the complete rehabilitation team.

Some people with serious mental illness also pose a danger to others. This danger can vary from homicide (which is very rare) to yelling at loved ones. Epidemiological research suggests that, depending on diagnosis, people with serious mental illness are up to six times more likely to be violent than the rest of the population (Corrigan & Watson, 2005; Swanson, Holzer, Ganju, & Jono, 1990). Concomitant use of alcohol and other drugs increases the rate of violence 20- to 30-fold. Moreover, symptoms related to paranoia and threat/control override also exacerbate violence (Link & Stueve, 1994; Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999). Interview items that assess threat/control override include the following:

1. How often have you felt that your mind was dominated by forces beyond your control?
2. How often have you felt that thoughts were put into your head that were not your own?
3. How often have you felt that there were people who wished to do you harm?

The two cautions about suicide also apply to an understanding of violence. First, any previous history of violence and threats should be considered in developing an appropriate intervention plan. Second, the presence of anger or threat does not necessarily
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preclude pursuit of other rehabilitation goals. Rather, the person and his or her family and rehabilitation team need to make this issue a priority in pursuing life goals. Concerns about violence and danger are discussed more thoroughly in Chapter 13.

Insight into Symptoms

One might think that psychiatric symptoms and related dysfunctions would dominate a person’s awareness. It might be assumed that people with mental illness would be concerned about problems with emotion, perception, cognition, motivation, interpersonal relations, or danger, and therefore would be highly motivated to participate in treatment to resolve these problems. However, many people with psychiatric diagnoses are unaware that specific experiences are symptomatic of mental illness (Amador & David, 1998). Lack of insight may occur for three reasons. First, it may be the direct result of the biological deficits caused by the illness. For example, deficits in the frontal lobes of the cerebral cortex commonly found in some people with schizophrenia are associated with diminished insight. This area of the cortex is associated with metacognitive processes related to the observing self—that is, the cognitive process that helps the person check how well he or she is (Lysaker et al., 2013).

Alternatively, not recognizing symptoms as mental illness may have secondary gain. Namely, labeling oneself as “mentally ill” may evoke both public and internal stigma. If the person does not admit that certain experiences are symptoms of mental illness, thereby denying the psychiatric disorder, the person can escape the stigma (Lally, 1989). Third, what mental health professionals perceive as symptoms may be experienced as consistent with a person’s image of him- or herself. For example, frequent rage and angry interactions with others may be perceived as “normal life” by some people. This misperception of symptoms is especially common in people with personality disorders (Millon & Davis, with Millon, Escovar, & Meagher, 2000).

What implications does lack of insight have for treatment? Poor insight into one’s disease predicts poor outcome; that is, people are less able to use interventions to control their symptoms and meet their life goals (Amador, 2010). In addition, lack of insight undermines full understanding and participating in treatment plans (Lysaker et al., 2013). The traditional notion of psychiatric care was that people had to recognize and admit their mental illness for significant treatment benefits to occur. In its absence, some people might resist participating in effective interventions. Most rehabilitation providers now realize that focusing on disease acceptance can lead to an unnecessary struggle. For example, the perception that people who did not admit their schizophrenia would not progress until they did so, and that a provider “should” motivate such a person into recognizing his or her illness, is now considered dated (Corrigan, Liberman, & Engel, 1990). Today’s rehabilitation providers avoid this battle, instead partnering with these persons by helping them to identify life goals and develop rehabilitation plans to achieve these goals. People can go back to work whether or not they admit they have schizophrenia.

Epidemiology

Epidemiologists seek to address public health questions about how many people meet criteria for specific disorders (Robins, 1978; Tsuang, Tohen, & Zahner, 1995). Incidence rates represent new cases that emerge in a healthy population within a fixed time frame (often 1 year). Prevalence rates represent the proportion of the population meeting
criteria for a disease at a specified point or period of time. Working at the population level allows researchers to understand the biological, behavioral, psychological, social, and economic variables that predict risk and course of various disorders. Public health officials use this information to set priorities in treatment policy and to track the impact of specific approaches on the diagnosis in the population.

**Etiology**

One purpose of diagnosis in medicine is to classify people with similar disorders into groups that share similar etiologies or causes. For example, people with respiratory symptoms and with test results suggesting a bacterial infection may be diagnosed with pneumonia, which may be effectively treated by antibiotics. Psychiatry has been less successful in developing a diagnostic system that corresponds with etiology. Being diagnosed with major depressive disorder, for example, does not automatically suggest a specific set of causes. Despite this limitation, psychiatry has made huge strides in identifying what causes and exacerbates the serious mental illnesses that lead to psychiatric disabilities.

**Biological Factors**

Clearly, research has not substantiated the out-of-date notions that mothers, fathers, or other family members cause mental illnesses because of bad parenting. Instead, research has identified biological processes that may explain the development of these disorders. A complete discussion of these processes is beyond the scope of this text. In brief, research has suggested two sets of factors that may yield a diagnosis consistent with disorders like schizophrenia:

1. **Genetic factors.** Population approaches to genetics, as well as the newer field of molecular genetics, have clearly implicated genetic inheritance as a primary cause of schizophrenia and the mood disorders. Research at this point seems to support a complex multifactorial pattern of inheritance rather than a single gene (Cannon, van Erp, & Glahn, 2002).

2. **Obstetric complications.** Adverse intrauterine events are associated with later onset of schizophrenia (Crow, 2003). For example, mothers who contract influenza during the second trimester of pregnancy are significantly more likely to give birth to children who later show signs of schizophrenia than are comparison groups of mothers (Machon et al., 2002).

**The Stress–Vulnerability Model**

Biological factors are not sufficient to explain the onset and course of most serious mental illnesses, however. Researchers have developed a stress–vulnerability model (see Figure 1.1) that integrates biological vulnerabilities with environmental stressors to explain how serious mental illnesses such as schizophrenia occur (Green, 1998; Nuechterlein et al., 1992). According to this model, genetic and other biological factors may make some people vulnerable to stress. When this vulnerability is overwhelmed, typically in late adolescence or young adulthood, the person experiences prodromal symptoms (the subtle, usually nonpsychotic signs of an illness that precede the first episode). Continued stress yields a full-blown psychotic episode and onset of the disorder. With treatment, the psychosis may remit; however, subsequent stress may cause relapse or residual symptoms.
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Research on this model has shown that common events that occur as part of “normal” life development can cause sufficient stress to overwhelm a vulnerable person (Horan et al., 2005). Such events may include leaving home when launching from one’s family of origin, starting a job, or getting married. Moreover, some stressful family interactions can overwhelm a person’s vulnerability (Butzlaff & Hooley, 1998; Pruessner, Iyer, Faridi, Joober, & Malla, 2011). Protective factors that can diminish the person’s vulnerability to stress may prevent subsequent relapses. Broadly speaking, these factors include psychotropic medication, interpersonal and instrumental skills, and social support. In some ways, these protective factors are the basic foundation on which rehabilitation is provided.

COMMON DIAGNOSES AMONG PSYCHIATRIC DISABILITIES

Four general diagnostic syndromes are commonly associated with psychiatric disability: schizophrenia, mood disorders, anxiety and related disorders, and personality disorders such as borderline personality disorder. (Note that I continue to use the still-common term mood disorders throughout this text for the depressive disorders and bipolar disorders, although DSM-5 has now divided these two groups into separate categories. I also continue to consider PTSD and OCD together with the anxiety disorders, although, as noted earlier, these two disorders now have their own categories in DSM-5.) I do not mean to imply that these are the only diagnoses relevant to psychiatric rehabilitation. Any of the diagnoses grouped under Axis I before the publication of DSM-5—other than a solitary diagnosis of mild substance use disorder or developmental disability; childhood disorders; or disorders with onset in elder adults, such as the dementias—may be considered the cause of psychiatric disabilities and be relevant for psychiatric rehabilitation.
Still, these four groups of disorders account for the vast majority of people with psychiatric disabilities, and therefore are most common in rehabilitation practice.

**Schizophrenia**

Schizophrenia is one of the psychotic disorders that lead to psychiatric disabilities. DSM-5 defines *psychosis* at various levels. The narrowest definition is restricted to evidence of delusions or prominent hallucinations, with the person not having insight into the pathological nature of hallucinations. A broader definition includes other positive symptoms such as disorganized speech or grossly disorganized behavior (positive symptoms are the florid signs of psychosis). Most people with schizophrenia will be challenged by significant disabilities and unable to achieve life goals in most domains. In fact, inherent to the definition of schizophrenia are psychotic symptoms that interfere with major life functions. Schizophrenia is more accurately considered a *spectrum disorder*—namely, a variety of disorders that may vary in course and outcome but share similar symptoms and dysfunctions. Epidemiological research has shown a 1.5% lifetime prevalence for the various disorders in the spectrum (Regier et al., 1988).

Other diagnoses on the schizophrenia spectrum include schizoaffective and schizotypal disorders. Schizoaffective disorder combines a period of schizophrenia with either a major depressive or a manic episode. The differential diagnosis between schizoaffective disorder and schizophrenia may have important medication implications. Namely, individuals with schizoaffective disorder may benefit from mood stabilizers, as well as antipsychotic medication, to address the affective components of their illness. People with schizotypal personality disorder are frequently included among the schizophrenia spectrum disorders and is also associated with significant impairment.

In addition to spectrum diagnoses and subtypes, schizophrenia has been defined in terms of positive and negative symptoms (Andreasen & Olsen, 1982; Khan et al., 2013). Positive symptoms represent the florid signs of psychosis and include hallucinations, delusions, grossly disorganized behavior, and inappropriate affect. Negative symptoms are sometimes called the *deficit syndrome* and represent the absence of normal functioning seen in many people with schizophrenia (i.e., alogia, avolition, and affective flattening). Typically, positive symptoms are more episodic and fluctuating over time than negative symptoms are. Although originally positive and negative symptoms were thought to be mutually exclusive syndromes representing different etiological processes (Crow, 1982), research now indicates that people with schizophrenia can manifest both clusters of symptoms (Ho & Andreasen, 2001). Of more relevance to rehabilitation practitioners, research has suggested that assessment of positive and negative symptoms has been useful for prognosis and treatment planning. Research suggests that positive symptoms, as opposed to negative symptoms, respond well to traditional antipsychotics as well as to many of the atypical antipsychotic medications (Ho & Andreasen, 2001); see Chapter 8 for a more complete discussion of medications. Noticing this trend, researchers have
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sought to improve the impact of some antipsychotics on negative symptoms. Research also suggests that the prognosis for negative symptoms is worse than that for positive symptoms, especially in the psychosocial treatments that often constitute psychiatric rehabilitation (Crow, 1995; Mäkinen, Miettunen, Isohanni, & Koponen, 2008). Nevertheless, there is no indication that the presence or severity of positive and/or negative symptoms precludes someone from participating in and benefiting from rehabilitation programs.

Mood Disorders
Symptoms related to mood define major depression: People have long periods of time with prominent sadness and/or have significant anhedonia (i.e., loss of enjoyment of almost all human activities and interactions, including those that were previously reported as pleasurable). In addition, people with major depression may experience cognitive, motivational, and interpersonal symptoms and dysfunctions. Many people with major depression also experience vegetative signs. These are changes in major life functions (e.g., sleep, appetite, and energy). Interestingly, these changes can represent either an increase or a decrease from a person’s typical baseline. Thus many people with major depression report either sleeping significantly more or not being able to sleep as much; either eating more than usual (leading to noticeable weight gain) or decreased appetite; and either having little energy or experiencing high levels of agitation.

Mood disorders are among the most common of psychiatric disorders (Meng & D’Arcy, 2012). Approximately 17% of the adult population will meet criteria for a major depressive episode at some point in their lives (Blazer, Kessler, McGonagle, & Swartz, 1994). Some of these people, however, will not suffer long-term disabilities because of their illness. People with bipolar disorders are more likely to experience significant disabilities. Typically, people with bipolar disorders experience separate periods of major depression and of mania, interspersed with periods of normal mood. Manic and depressed episodes can last weeks or even months. Periods longer than several months are atypical, especially in terms of mania, and might represent the more benign cyclothymic disorder. Episodes as short as a few days followed by an episode of opposite polarity are not uncommon.

DSM-5 distinguishes bipolar disorders into two major types: bipolar I and bipolar II. Both disorders are marked by interspersed periods of major depression and some version of mania or hypomania. People with bipolar I, the more severe of the two types, experience full-blown manic episodes, typically with psychosis. People with bipolar II experience hypomanic episodes, which include many of the “sped-up” symptoms and dysfunctions of mania but in less severe forms (i.e., there are no psychotic symptoms, little need for hospitalization, and less impairment of functioning). Although people with either form of bipolar disorder may experience psychiatric disabilities, those with bipolar I disorder are more likely to need the assistance of rehabilitation programs.

Anxiety and Related Disorders
Anxiety disorders and related disorders (PTSD and OCD, which, as noted above, now have their own categories in DSM-5) are frequently viewed by the public as less disabling than the schizophrenia spectrum disorders and the mood disorders. Epidemiological research tends to support this notion for the population (Kessler, DuPont, Berglund,
However, individuals with these disorders may still struggle with significant life disabilities for prolonged periods of time. In addition, anxiety and related disorders frequently co-occur with one of the schizophrenia spectrum disorders or mood disorders, and such a combination is likely to yield significant life disabilities (Lysaker & Salyers, 2007). Although any of the anxiety or related disorders alone can lead to disabilities requiring psychiatric rehabilitation, three in particular may present themselves in rehabilitation clients.

The essential features of OCD are recurrent obsessions (persistent thoughts that are experienced as intrusive) or compulsions (repetitive behaviors that a person feels driven to perform), which are sufficiently severe to be time-consuming or cause significant impairment. Common examples of obsessions include thoughts about contamination or cleanliness, repeated doubts, need for order, aggressive impulses, and sexual images. Common compulsions include washing, counting, checking, requesting assurance, or repeating actions. Typically, people with OCD recognize that their obsessions or compulsions are unreasonable or excessive. The time spent on obsessions or compulsions, as well as the distress they cause, can significantly interfere with persons' pursuit of their life goals.

Agoraphobia involves anxiety about being in places or situations from which escape is difficult or embarrassing. For many people, this manifests as an unwillingness to leave home so as not to risk these kinds of situations. Avoidance of situations frequently impairs a person's ability to travel outside the home, thereby undermining work and other independent living goals. PTSD occurs following exposure to an extreme traumatic stressor that involves actual or threatened death, serious injury, or sexual violence to self or others, and that leads to intense fear, helplessness, or horror. The subsequent experience of symptoms may happen immediately after the traumatic event or may be delayed months or years. The symptoms that correspond with PTSD include some form of reliving the event, accompanied with intense emotional arousal. Research suggests that many persons with a diagnosis of schizophrenia or a mood disorder have a history of trauma or full-blown PTSD, which worsens their disabilities considerably (Mueser, Rosenberg, Jankowski, Hamblen, & Descamps, 2004b; Subica, Claypoole, & Wylie, 2012). Alternatively, significant trauma or PTSD can interfere with life goals in its own right, leading to the need of rehabilitation practices.

**Personality Disorders**

As outlined in DSM-5, personality disorders are ways in which people relate to and think about their environment and themselves. Symptoms and dysfunctions of the personality disorders are frequently inflexible or otherwise maladaptive manifestations of typical personality traits. Personality disorders are organized into three clusters. Cluster A includes paranoid, schizoid, and schizotypal personality disorders; individuals meeting criteria for these diagnoses often appear eccentric or odd. Cluster B comprises antisocial, borderline, histrionic, and narcissistic personality disorders; people with these diagnoses may seem dramatic or emotional. Cluster C includes avoidant, dependent, and obsessive–compulsive personality disorders, in which individuals appear anxious or fearful. Although any of these 10 disorders can lead to significant disabilities and the need for rehabilitation, much has been written in particular about psychosocial services for people with borderline personality disorder (BPD; Linehan, 1993; Zanarini, Frankenburg, Reich, & Fitzmaurice, 2010).
BPD is marked by a pervasive pattern of instability in social relationships, self-image, and emotions, exacerbated by severe impulsivity. Impulsive behaviors can include self-mutilation or suicide. Because their relationships are so tumultuous, people with this disorder frequently lack a support network of individuals who can help them cope with even the most minor problems. As a result, minor depression and anxiety can explode into overwhelming stress. People with BPD may have significant difficulty in accomplishing employment, relationship, and other independent life goals because of these symptoms, and thus in benefiting from rehabilitation.

**Additional Information for an Accurate Psychiatric Diagnosis**

Presence or absence of diagnostic criteria as assessed during a single interview is usually not sufficient to enable a provider to make a diagnosis. It is almost impossible to decide whether a person presenting with depression and psychotic symptoms at a single clinic visit has major depressive disorder, schizophrenia with depression, schizoaffective disorder, a bipolar disorder, a substance-induced disorder, or some combination thereof. Complete diagnosis requires two additional elements in addition to assessment of symptoms and dysfunction.

1. **History.** What kind of impact have the symptoms and dysfunctions had on the person over time? The next section of this chapter examines this question in terms of the course of the disorder.

2. **Depth of impact.** How much does the illness interfere with the person’s life? Does it lead to an occasional acute crisis, followed by significant periods where symptoms are in remission and life goals are accomplished? Or does the illness significantly disrupt the person’s functioning and his or her life plans? This chapter ends with a consideration of the various kinds of disabilities that may be associated with psychiatric disorders.

**COURSE OF THE PSYCHIATRIC DISORDER**

The symptoms, dysfunctions, and disabilities that constitute psychiatric disorders are dynamic phenomena; that is, they change throughout a person’s life. Key milestones help to explain disease course, including onset of the disorder and the prodromal period leading up to its ongoing disease trajectory once the illness has begun; and end state. As outlined in Figure 1.2 for schizophrenia, each milestone may be described as one of two types. The onset may occur over a slow and chronic course, or it may be sudden or acute. The trajectory may be simple and unchanging, or it may represent undulating waves that vacillate between significant symptoms and remission. The end state may be severe and unremitting, or recovery may occur. Each of these milestones is reviewed more fully below.

**Disease Onset**

Onset for most of the mental illnesses that lead to psychiatric disabilities and rehabilitation often occurs in late adolescence or early adulthood. The period preceding the onset of the full-blown disease is known as the prodrome. As outlined in Figure 1.2, the prodromal course may be brief and acute, or it may be chronic and insidious. Onset of
the disease is more of a shock to the people with acute onsets and their families. Typically, the person was experiencing few psychiatric problems prior to the full-blown set of symptoms characteristic of the illness. The subsequent course of a person with acute onset is frequently more benign than that of a person with chronic onset (Moller & von Zerssen, 1995).

For those with an insidious and chronic onset, the prodrome can be a brief period of months or can extend over several years. Because it is slow and insidious, the person and his or her family often do not identify the prodrome as signaling psychiatric illness. In this case, the prodrome is marked by subtle forms of the symptoms that characterize the illness. For example, people who end up with schizophrenia may show such signs as ideas of reference (rather than delusions), odd beliefs or magical thinking, and unusual perceptual experiences (e.g., body illusions). Presence of symptoms like these during adolescence or young adulthood does not necessarily mean that the person’s disorder will develop into a full-blown psychotic disorder. Alternatively, such symptoms may signal onset of the less disabling schizotypal personality disorder.

Early and accurate assessment of the onset of serious disorders like schizophrenia is important for the subsequent impact of interventions. Research has shown that the duration of untreated psychosis (the period in which the prodrome is not correctly identified as leading up to psychosis) is positively associated with poor outcome in terms of relapse and inversely associated with remission (Fraguas et al., 2014; Jablensky et al., 1992; Loebel et al., 1992). Hence early intervention programs have been developed and evaluated to treat people soon after psychosis first emerges. One possible goal of these kinds of programs is to help people avoid disabilities by learning to manage their illness from the start. For this reason, early intervention programs typically do not fall under the rubric of psychiatric rehabilitation. These issues are discussed more fully in Chapter 6.
**Ongoing Trajectory**

Although some serious mental illnesses are short in duration, most disorders that are relevant to psychiatric rehabilitation last for years. The trajectory of serious mental illness is described by two patterns. Some people experience a relatively simple or flat trajectory, in which symptoms, dysfunctions, and disabilities do not change much from the onset. Alternatively, many people with serious mental illness experience an undulating pattern, in which symptoms, dysfunctions, and disabilities wax and wane. Undulating patterns can be regular and episodic—that is, described by regular shifts from disease states to remission (Modestin, Huber, Satirli, Malti, & Hell, 2003). Research has not clearly determined what might account for these rhythms, but possible factors may include biological patterns (e.g., monthly hormonal changes (Halbreich & Kahn, 2003), social schedules (e.g., regular stresses at work), or anniversaries of earlier traumatic events (Mueser, Rosenberg, Goodman, & Trumbetta, 2002b). Irregular patterns are more common, however, in which recurring waxing and waning are not predictable.

Decreases of symptoms and dysfunctions from the acute and severe level are described by two phases. During the *residual phase*, symptoms and dysfunctions have markedly decreased from the acute level, but the person still experiences problems that result from attenuated versions of the disorder. Hence the person has less severe psychiatric problems than in the acute phase of the illness, but is still likely to be disabled by the disorder. In other instances of serious mental illness, a person experiences total *remission* of symptoms and dysfunctions during benign periods of the course; in other words, the person returns to preprodromal levels. Generally, evidence of remission during the trajectory suggests a better end state than when only residual phases are experienced.

**End State**

What becomes of people with serious mental illnesses? Early psychiatric models mostly predicted negative results. Schizophrenia, for example, was thought to result in a progressive downhill course. Kraepelin (1896) called schizophrenia *dementia praecox* or a “precocious dementia,” because he believed that the loss of dysfunction was irretrievable, as in most dementing illnesses. Several long-term follow-up research projects were completed to test this assertion; most of this research was done on schizophrenia. In these types of studies, people with schizophrenia were typically identified while in a psychiatric hospital and then followed from 10 to 30 years to determine end state. Findings from prominent studies of this kind are summarized in Table 1.1. The table lists the criteria used by each study to determine improvement or recovery.

If Kraepelin were correct, we would expect the vast majority of (if not all) people with schizophrenia still to be symptomatic and dysfunctional, and not to be working or living independently at follow-up. Instead, each of the studies found that schizophrenia has a heterogeneous range of end states, from severe cases requiring repeated or continuous hospitalization to cases in which a single illness episode is followed by complete remission of symptoms. The findings reported in these studies as a whole indicate that roughly half of participants recovered or significantly improved over the long term, suggesting that remission or recovery is much more common than originally thought.

**Early Intervention**

Researchers and clinicians realize that the earlier a serious mental illness is addressed in the course of the disorder, the better the outcomes. For example, a person experiencing
1. People with Psychiatric Disabilities

The onset of schizophrenia who becomes engaged in a psychiatric rehabilitation program within the first year of the disorder is likely to respond better to interventions than a person who waits longer will. Clinicians have described duration of untreated psychosis—the period between first experiencing symptoms and receiving services—as a key metric for early intervention (Callaly, 2014). Early consideration of identification and intervention first emerged for schizophrenia (Petersen, Bhana, Lund, & Herrman, 2014), but has been extended to depression and anxiety disorders (Nazareth & Kendrick, 2014).

### TABLE 1.1. Summary of Long-Term Follow-Up Studies on Schizophrenia

<table>
<thead>
<tr>
<th>Name of study</th>
<th>% recovered or improved</th>
<th>Average follow-up</th>
<th>Improvement/recovery criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burgholzli Study (Bleuler, 1978)</td>
<td>53%</td>
<td>23 years</td>
<td>5-year “end state” determined through clinical interview by Bleuler.</td>
</tr>
<tr>
<td>Iowa 500 Study (Tsuang &amp; Winokur, 1975)</td>
<td>46%</td>
<td>35 years</td>
<td>Marital, residential, occupational, and symptom status rated on 3-point scales and combined into a global measure.</td>
</tr>
<tr>
<td>Bonn Hospital (Huber et al., 1980)</td>
<td>56%</td>
<td>22 years</td>
<td>Symptoms and social functioning assessed by exam. Social recovery was defined as full-time employment.</td>
</tr>
<tr>
<td>Lausanne Study (Ciompi, 1980)</td>
<td>49%</td>
<td>37 years</td>
<td>Bleuler’s 5-year “end state” criteria.</td>
</tr>
<tr>
<td>Chestnut Lodge (McGlashan, 1984)</td>
<td>36%</td>
<td>15 years</td>
<td>Personal interview in which examiner rated subject on hospitalization, employment, social activity, psychopathology, and a global functioning score that combined these factors.</td>
</tr>
<tr>
<td>Japanese Study (Ogawa et al., 1987)</td>
<td>57%</td>
<td>21–27 years</td>
<td>Follow-up interviews emphasizing social relationships and residential status.</td>
</tr>
<tr>
<td>Vermont Study (Harding et al., 1987b, 1987c)</td>
<td>68%</td>
<td>32 years</td>
<td>Interviews using structured instruments for the collection of data on social functioning, hospital records, various symptom-based measures summarized with the Global Assessment Scale.</td>
</tr>
<tr>
<td>Cologne Study (Steinmeyer et al., 1989)</td>
<td>36%</td>
<td>25 years</td>
<td>Interviews using the Global Assessment Scale, the Disability Assessment Schedule, the Psychological Impairment Rating Schedule, and the Bonn criteria for categorization of psychopathological outcome.</td>
</tr>
<tr>
<td>Maine Sample (DeSisto et al., 1995)</td>
<td>49%</td>
<td>36 years</td>
<td>Criteria replicated the Vermont Study. The Global Assessment Scale provided a global measure of psychological and social status.</td>
</tr>
<tr>
<td>International Study of Schizophrenia (Harrison et al., 2001)</td>
<td>56–60%</td>
<td>15 and 25 years</td>
<td>Bleuler global assessment based on all information on course, symptoms, and functioning.</td>
</tr>
</tbody>
</table>

Note. Data from Corrigan and Calabrese (2005).
Understanding Psychiatric Disabilities

2014), substance use disorders (Newton, Deady, & Teesson, 2014); and eating disorders (Pinhas, Wong, & Woodside, 2014). Clinicians and researchers have even proposed strategies for the perinatal period (St-Andre, Schwartz, & Yoshida, 2014), as well as for infancy and early childhood (Barlow, 2014). Early intervention has required a paradigm shift in which providers partner with community members or institutions (e.g., schools) to respectfully identify people with these challenges and engage them in interventions (McGorry, 2012). The nature of these interventions is reviewed in Chapter 6 on illness self-management.

Criteria for Recovery

Different dimensions of outcome and end state, such as symptom levels and psychosocial functioning, have generally been found to intercorrelate to only a modest degree (Strauss & Carpenter, 1972, 1974, 1977; Harding, Brooks, Ashikaga, Strauss, & Breier, 1987a, 1987b). For this reason, the choice of which dimensions to use as criteria for recovery is important. Some investigators (e.g., McGlashan, 1984) believe that a study must use multiple dimensions to provide a comprehensive and valid picture. However, one may also argue that presence of symptoms within an otherwise functional life should not disqualify an individual from being judged as “recovered.” Psychosocial functioning is arguably a more important criterion of recovery than being symptom-free, and an overreliance on symptom-based criteria, together with the false assumption that symptoms and functioning are strongly correlated, may partially explain why the pessimistic Kraepelinian view of schizophrenia has persisted. Reliance on global ratings of outcome collapses these differences, making the exact nature of outcomes unclear.

In many cases, persons with schizophrenia have learned ways to cope with and manage symptoms when they arise. In cautioning against the criterion of presence versus absence of symptoms, Liberman, Kopelowicz, Ventura, and Gutkind (2002) have argued that positive symptoms experienced during a given follow-up period may last only days or weeks, and may have a minimal impact on social or occupational functioning. In addition, the International Study of Schizophrenia (Harrison et al., 2001) found that 20% of participants maintained employment despite persisting symptoms and/or disabilities. In any case, we certainly should not limit outcome to positive psychotic symptoms, given that negative symptoms, anxiety, and depression may be much more disabling than positive symptoms in a given case (Liberman, 2002).

Course Predictors and Modifiers

Research has identified several factors that either predict or modify the course of serious mental illness, including family history, stress, and substance use, as well as some demographic characteristics (e.g., age of onset, gender), and some socioeconomic variables. These are relevant concepts to keep in mind as rehabilitation plans are developed to help people achieve their life goals. However, neither a person with a psychiatric disability nor the person’s rehabilitation team should feel bound by predictions that correspond with individual factors. A person with serious mental illness who is motivated to achieve work, independent living, and other life goals will be able to achieve these goals, regardless of course predictors or modifiers, with appropriate rehabilitation services. The factors of family history, stress, and substance use are reviewed more fully below.
Family History

Having biological relatives with serious mental illness is probably the best predictor of disease onset, because it is a proxy for probability that a person has inherited a genetic vulnerability (Donatelli, Seidman, Goldstein, Tsuang, & Buka, 2010; Kendler et al., 1993). For example, having a first-degree relative (a parent or sibling) with schizophrenia increases the person’s likelihood of schizophrenia 10-fold (Kendler & Diehl, 1993). Individuals with an identical twin diagnosed with schizophrenia have a 50% chance that they too will contract the disorder (Gottesman & Erlenmeyer-Kimling, 2001; Kendler & Diehl, 1993). Note, however, that only a 50% risk rate in a genetically identical person implicates nongenetic factors such as stress as important in terms of the onset and trajectory of serious mental illness.

Stress

As discussed earlier in this chapter, people with serious mental illnesses are thought to be vulnerable to stress. Psychosocial stressors are frequently implicated in the onset of a disorder, as well as in causing relapse when a person is in remission (Bebbington et al., 1993; Ventura, Nuechterlein, Lukoff, & Hardesty, 1989). Psychosocial stressors may take the form of everyday life events—that is, the kind of life demands arising from work, independent living, and intimate relationships. Life events are particularly stressful at times of loss (e.g., being fired from a job or getting a divorce) or change (e.g., moving residences or offices). Stressful relationships can also overwhelm a person’s vulnerability and cause symptom relapse (Schreiber, Breier, & Pickar, 1995).

Substance Use

People who use and abuse alcohol and other drugs are likely to have a more malignant course and end state. In fact, the impact of co-occurring substance abuse, and the prevalence of this problem among people with psychiatric disabilities, has become a dominant issue among rehabilitation providers. The problem is described more thoroughly in the next section, and corresponding interventions are addressed in Chapter 16.

Disabilities

Disabilities are the definitive foci of psychiatric rehabilitation, and are what distinguish it as an approach to services from approaches based more on psychopharmacology or psychotherapy. As noted earlier, disabilities are those psychological phenomena that arise from psychiatric illness to block goals in the key life domains. Perhaps most important about the focus on disability is the way it defines the mission of psychiatric rehabilitation. Other approaches to psychiatric care may target diminishing symptoms or dysfunctions. The goal of psychiatric rehabilitation is to help people overcome their disabilities so that they are able to achieve their life goals. People may be able to achieve life goals in this manner while still experiencing significant symptoms and dysfunctions.

Age and Culture Defined

What are appropriate life goals? Consistent with rehabilitation’s commitment to personal empowerment, persons with psychiatric disabilities are best able to answer this question
for themselves. However, most cultures have age-defined goals that are benchmarks of achievement; these are defined in terms of role attainment in North America. The prototypical young to middle-aged adult in the United States and Canada is assumed to pursue and/or accomplish the following goals:

- Launch from family of origin and set up an independent household.
- Complete the necessary education and training to pursue a vocation.
- Obtain at least an entry-level position commensurate with vocational goals.
- Begin to achieve income goals so that the person can be self-sustaining.
- Find a mate with whom to share an intimate, long-term relationship.
- Develop personally meaningful approaches to address recreational and spiritual needs.

Note that these goals are defined as age-specific. Hence we would expect younger adults to be first engaging in the pursuit of some of these goals, while older adults might be moving away from the pursuit of some. The goals are also defined in terms of culture: Those listed here largely represent a mainstream North American/Western European ethos. It is up to rehabilitation providers to understand culture-specific goals within the culture(s) of the people they serve. Suffice it to say here that cultural definitions of life goals are likely to change across national borders, as well as within ethnically diverse countries. In the United States, for example, the goal of launching from the family is likely to differ for African Americans, Hispanics, and Asian Americans. Even with these additional guidelines, the rehabilitation provider must remember that ultimate definitions of specific goals depend on people's experience with their culture, and on their personal desires given these experiences.

Disability Domains and Life Goals

Absence of symptoms and dysfunctions does not a good life make. Instead, quality of life depends on achieving goals in the major life domains (Lehman, 1988; Skantze, Malm, Dencker, May, & Corrigan, 1992). At a minimum, these goals should include satisfaction of basic needs (e.g., safe, private, and comfortable housing); stimulating and financially beneficial work; comprehensive physical, dental, and mental health care; sufficient financial resources; transportation and access throughout one's community; and adequate legal counsel. A good quality of life also requires some sense of satisfaction with more transcendent desires: support networks including family, friends, and coworkers (or fellow students, depending on the situation); recreation, both alone and with others; intellectual stimulation; and spiritual life (Davis & Brekke, 2014; Nolan et al., 2012). I define a good quality of life in the remainder of this section in terms of five domains: independent living; education and employment; relationships; health; and spiritual life and recreation. Goals in these domains are goals that are blocked by disabilities. Note that these five domains are at the heart of the chapters on service approaches.

Independent Living

Most adults in Western cultures seek to launch from their families of origin and set up households that reflect their adult tastes and interests; for the typical adult, this means renting or buying a residence. Housing goals usually include safe neighborhoods, dwellings of a reasonable size and with appropriate amenities, and housing in good condition.
Sometimes people with psychiatric disabilities need support from rehabilitation providers to live successfully in their own homes. Rehabilitation providers need to make sure that the institutional demands of their agencies do not interfere with this goal. For example, agency regulations should not limit people’s options in regard to the neighborhoods where they live or the types of housing they wish to obtain.

An equally important part of independent living is the decision about with whom a person resides. Options include family members (either family-of-origin members or members of a family created in adulthood—e.g., spouse and children), friends, roommates who help defray costs, or no one. In all cases, people need to decide for themselves with whom they want to live. Rehabilitation providers do not impose roommates on individuals because of institutional necessity. Adults are changeable creatures; desires about whom they choose to live with change over time. Perhaps a divorce is necessary. Perhaps older parents must move into assisted living, and people with disabilities must learn to live alone. Whatever the reasons, rehabilitation providers need to assist people with the evolution of their independent living needs.

### Education and Employment

Work serves many goals in North American culture. It is the basis on which most adults obtain an income to achieve their independent living goals. It is a source of identity; many people describe themselves in terms of their jobs. Indeed, work-related issues often dominate conversations with friends and family members, and take up major portions of individuals’ time and energy. Work also provides a sense of place within the larger context of society. In no way is place meant here to suggest caste (i.e., the notion that some jobs denote better status than others). Rather, place is meant in the concrete sense, as defining where a person goes daily and with whom the person associates. In addition, work is frequently the source of vocation—namely, the belief that “I, as an individual, am involved in personally meaningful industry.” Industry does not refer here to an economic sector, but rather to the psychological life function of being industrious or busy. For reasons like these, work is a significant priority for the general adult population and for people with psychiatric disabilities alike (Aizawa & Hisanaga, 2012; Rogers, Anthony, Toole, & Brown, 1991a).

Education is the typical path many people take to begin accomplishing work goals. It provides the general credentials, such as a high school or college diploma, necessary for most jobs. Education teaches basic skills that are needed to be successful on the job. It also may provide work-specific talents that are necessary for jobs in varying sectors (e.g., computer skills needed in an information technology position). Moreover, education provides nonspecific gains that are important for many young adults. It provides many with a sense of competence and mastery. Intellectual stimulation is also of interest to many adults and may continue in adult education programs after the needs for credentials and certification have passed.

### Relationships

Most adults have broad and significant interests in interpersonal relationships. They seek to change the form of interactions with their family-of-origin members from one of dependence to launching, becoming independent, and setting up an ongoing, mutually loving relationship with parents and siblings. Adults search for significant others with whom they can be intimate and develop long-standing relationships. In many cases, these
intimate relationships yield children, with all the promise and challenges they entail. Adults also seek to extend their networks of friends, neighbors, and coworkers.

**Health**

All adults have physical, dental, and mental health problems that vary in severity. People with psychiatric disabilities seem to have an inordinate number of significant physical illnesses, which may be related to lifestyle issues (Druss et al., 2000b). Rehabilitation programs seek to help them not only work closely with the general medical system to address these immediate illnesses, but also address the lifestyle decisions that may be exacerbating these illnesses. Although by definition, people with psychiatric disabilities have significant mental illness, not all mental illness may cause distress. For example, some aspects of mania are experienced as pleasant, and some experiences of personality disorder are not viewed as mental illness. Similarly, some hallucinations or delusions may not be disturbing to an individual, even though they are signs of psychosis. The rehabilitation provider’s task is to assist the person with psychopharmacological and psychotherapeutic interventions for symptoms that are distressing.

Health is not just an issue of avoiding illness. Adults also seek wellness. This includes physical issues related to diet and exercise. In addition, it includes those physical, psychological, and spiritual experiences that help a person achieve what he or she views as a personally full and meaningful life.

**Spiritual Life and Recreation**

Work, relationships, health, and housing are not enough for a meaningful adult life. Recreation provides an opportunity to broaden one’s interaction with and enjoyment of the world. Recreation may involve formal planned activities (e.g., hobbies) or spontaneous experiences. Family, friends, and others are sometimes important for recreation. Some forms of recreation require significant resources, while others can be enjoyed without such assets. The rehabilitation provider helps the person survey activities that may be recreational for him or her, and obtain access to these activities. The rehabilitation provider also problem-solves with the person on how he or she can obtain the necessary resources to enjoy a specific type of recreation.

Social thinkers have distinguished *religiousness*, or participating in a community of people who gather around common ways of worshiping, from *spirituality*, or thinking about oneself as part of a larger spiritual force (Hill et al., 2000; Zinnbauer, Pargament, & Scott, 1999). One nationwide survey of people with psychiatric disorders showed that 67.5% of respondents viewed themselves as religious and 85.1% as spiritual (Corrigan, McCorkle, Schell, & Kidder, 2003b). Findings from this study also showed that both religiousness and spirituality were associated with psychological well-being and diminished psychiatric symptoms. Hence an important goal of rehabilitation providers is to help people with psychiatric rehabilitation explore their religious and spiritual goals, and to access services and people who will assist the persons in achieving these goals.

**SOCIAL DISADVANTAGE**

People with serious mental illness and psychiatric disabilities are often socially disadvantaged. They may have low incomes, may have less education, may be homeless, and
People with psychiatric disabilities frequently come from culturally disenfranchised groups. Research has not clearly determined whether social disadvantage leads to psychiatric disabilities or whether serious mental illness leads to a downward drift into social disadvantage (Draine, Salzer, Culhane, & Hadley, 2002; Nelson, 2002; Sheldon et al., 2006). Direction, however, is beside the point; many of the problems with which people with psychiatric disabilities struggle may be a function of their social disadvantage as much as, or more than, the symptoms and dysfunctions of their illness.

People with psychiatric disorders are often detained and subsequently involved in the criminal justice system. This can occur in both criminal and civil courts and can range from minor misdemeanors to charges involving severe violence. In fact, the jail and prison system is now believed to be the biggest provider of mental health services to people with serious psychiatric illnesses. The nature of these problems is more fully discussed in Chapter 14. There are three points to consider here. First, criminal and/or civil court involvement can significantly derail the pursuit of goals in the other five domains. Second, court participation and the coercion it frequently entails can be unsettling to most people in their own right. Third, these problems are likely to be caused by disabilities and by social disadvantage. Hence rehabilitation programs help people navigate the various levels and intricacies of the justice system, so they can meet the courts’ demands, cut their ties with the police, and return to their principal goals of independent living, work, relationships, and health.

People with serious mental illness get sick and die at much younger ages than peers. This is the primary topic of Chapter 15. In part, this situation reflects the lifestyles of people with psychiatric disabilities and the lower-quality physical health services that are often provided for this group. The research reviewed in Chapter 15 poignantly shows that health and health care are even worse for people with disabilities when they are from ethnic minority groups or have low incomes.

The message here reinforces the bidirectional mandate of rehabilitation services. Providers need to help people learn skills to accomplish goals in the face of their disabilities. However, providers also need to address community barriers that undermine goals. An effective rehabilitation program thus has its team members wear multiple hats. This point is made repeatedly in subsequent chapters.

**STRENGTHS FOCUS**

As stated earlier in the chapter, although discussion of diagnosis, symptoms, dysfunctions, course, and disabilities helps rehabilitation providers better understand the challenges faced by persons with serious mental illness, this kind of discussion tends to frame these persons as victims of their disabilities without recognizing the individuals’ positive assets. Each area of symptoms and dysfunctions specific to a disorder not only suggests problems blocking life goals, but also possible strengths on which a person may draw to accomplish his or her goals. Examples of possible strengths are summarized in Table 1.2. Note that this is not meant to be an exhaustive table. Instead, the rehabilitation provider must actively engage the person to assess what his or her specific profile of strengths might be.

Although affect is frequently distressed by psychiatric illness, people with psychiatric disabilities may have several strengths in this domain. Among other possibilities, emotions may motivate individuals to act against their symptoms and achieve their goals.
I. UNDERSTANDING PSYCHIATRIC DISABILITIES

People with psychosis often experience diminished perceptual and cognitive abilities. But despite these limitations, they frequently have the abilities to understand problems and brainstorm solutions (Corrigan & Toomey, 1995), as well as to perceive interpersonal situations correctly (Corrigan, Green, & Toomey, 1994). Among the greatest strengths a person with disabilities may draw upon is motivation. Namely, despite the hurdles thrown up by symptoms and dysfunctions, the person wants to achieve work, independent living, relationships, and other goals. Symptoms and dysfunctions often interfere with interpersonal relationships. Nevertheless, most people with serious mental illness have family members or friends on whom they might rely. Alternatively, rehabilitation providers or peers with psychiatric disabilities are also frequently available to step in for support and companionship.

### TABLE 1.2. Possible Strengths That May Correspond to the Domains Defining Symptoms and Dysfunctions

<table>
<thead>
<tr>
<th>Domains</th>
<th>Possible strengths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affect</td>
<td>• Experiences the full range of emotions.</td>
</tr>
<tr>
<td></td>
<td>• Is concerned about emotions that are “out of control” or distressing.</td>
</tr>
<tr>
<td>Perception and cognition</td>
<td>• Is able to orient to task at hand.</td>
</tr>
<tr>
<td></td>
<td>• Is able to problem-solve.</td>
</tr>
<tr>
<td></td>
<td>• Is able to understand the basics of human interaction.</td>
</tr>
<tr>
<td>Motivation</td>
<td>• Is motivated to achieve specific goals.</td>
</tr>
<tr>
<td></td>
<td>• Is motivated to work with rehabilitation programs and other resources to accomplish goals.</td>
</tr>
<tr>
<td>Interpersonal functioning</td>
<td>• Has some family members, friends, neighbors, and/or coworkers who provide support and companionship.</td>
</tr>
</tbody>
</table>

People with psychosis often experience diminished perceptual and cognitive abilities. But despite these limitations, they frequently have the abilities to understand problems and brainstorm solutions (Corrigan & Toomey, 1995), as well as to perceive interpersonal situations correctly (Corrigan, Green, & Toomey, 1994). Among the greatest strengths a person with disabilities may draw upon is motivation. Namely, despite the hurdles thrown up by symptoms and dysfunctions, the person wants to achieve work, independent living, relationships, and other goals. Symptoms and dysfunctions often interfere with interpersonal relationships. Nevertheless, most people with serious mental illness have family members or friends on whom they might rely. Alternatively, rehabilitation providers or peers with psychiatric disabilities are also frequently available to step in for support and companionship.

### SUMMARY AND CONCLUSIONS

The answer to the question “Who are people with psychiatric disabilities?” is simple, as well as multilevel and complex. The simple definition is straightforward: People with psychiatric disabilities are, first and foremost, persons. They have the same types and breadth of life goals as others in their culture. Unfortunately, achieving these goals is undermined by the disabilities that arise from serious mental illness. They are also impeded by community factors and social disadvantage. Effective rehabilitation must therefore be bidirectional, addressing both individual and community factors.

The complexity of the answer to this chapter’s question lies in understanding the barriers to achieving life goals. Diagnoses represent mental illness syndromes comprising distressing symptoms and disabling dysfunctions. As a result, people are unable to accomplish social roles and goals in such important life domains as work, independent living, income, relationships, and health. Course of illness is described by a complex mix of onset, trajectory, and end state. Course of a disorder is exacerbated by several factors, including age of onset, gender, familial history, stress, and substance use. Co-occurring substance use, in particular, is a high-rate phenomenon in psychiatric disabilities that can have a serious effect on individuals’ life goals.
People with psychiatric disabilities are not well described solely in terms of their symptoms, dysfunctions, and disabilities. Their strengths constitute an equally important part of the picture. A focus on strengths reminds us that people with disabilities, like everyone else, are complex beings with many characteristics. A strengths focus also highlights the resources that may be drawn upon as a person engages in his or her rehabilitation plan. A combination of the simple picture of the person as person, with recognizing the individual’s strengths and limitations, provides the fullest answer to our opening question.

**PERSONAL EXAMPLE**

*Joel Jenkins Revisited*

This chapter has begun with the complex stories of four people with serious mental illness. What might we make of one of these persons, given the information reviewed in this chapter? How might the concepts reviewed in this chapter expand our understanding of Joel Jenkins and his needs for psychiatric rehabilitation?

Joel is experiencing what is likely to be an early phase of schizophrenia because of his age. His symptoms seem to be acute, tumultuous, and problematic for his parents. Frequent hospitalization is likely to be interfering with the kind of goals that would dominate a 22-year-old’s life: completing education, beginning one’s career, moving out of the family-of-origin home, and building intimate relationships. Instead, his frequent, hostile exchanges with his parents have yielded significant problems with the police. He is becoming enmeshed in the court system and finding his life options diminished by the demands of the judge. His court troubles appear to be further exacerbated by marijuana use: Smoking pot is evidently both worsening his symptoms and increasing police involvement in his life.

Joel has identified several life goals. He would like to move out of his parents’ home and find a place of his own. He recognizes that to do this successfully, he will need to find a job that pays a reasonable salary. He also recognizes that his recurring psychotic symptoms and agitation are likely to interfere with these goals in the short term. So, in addition to work with job and housing coaches, the rehabilitation team is helping Joel and his psychiatrist to manage his antipsychotic medications more effectively. Joel is also working on relapse prevention skills to diminish his use of marijuana.

Joel’s rehabilitation plan is influenced by his living in a small town. The breadth of services may be limited, requiring some innovation on the part of the rehabilitation team. Moreover, job hunting may be a bit more difficult in a small community where Joel is well known. Again, the rehabilitation team needs to think innovatively about how potential employers’ attitudes can be enhanced to make sure that stigma does not undermine Joel’s options.

Joel has several strengths. Despite the angry and sometimes violent battles at home with his parents, Joel’s mother and father are deeply committed to helping Joel beat his illness. Joel is also strongly motivated to get back to work, though admittedly his motivation to decrease his marijuana use waxes and wanes. Joel has engaged closely with his rehabilitation job coach to develop a reasonable plan for achieving his vocational goals.